An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Alternative Care - Inspection and Monitoring Service

Children's Residential Centre

Centre ID number: 198

Year: 2023

Inspection Report

Year:	**2023**
Name of Organisation:	**Attuned Programmes Ireland Ltd**
Registered Capacity:	**Single Occupancy**
Type of Inspection:	**Unannounced**
Date of inspection:	**10th & 11th January 2023**
Registration Status:	**Registered from 03rd August 2021 to 03rd August 2024**
Inspection Team:	**Joanne Cogley** **Sinead Tierney**
Date Report Issued:	**17th August 2023**

Contents

1. Information about the inspection process

The Alternative Care Inspection and Monitoring Service is one of the regulatory services within Children's Service Regulation which is a sub directorate of the Quality and Regulation Directorate within TUSLA, the Child and Family Agency.
The Child Care (Standards in Children's Residential Centres) Regulations, 1996 provide the regulatory framework against which registration decisions are primarily made. The National Standards for Children's Residential Centres, 2018 (HIQA) provide the framework against which inspections are carried out and provide the criteria against which centres' structures and care practices are examined.
During inspection, inspectors use the standards to inform their judgement on compliance with relevant regulations. Inspections will be carried out against specific themes and may be announced or unannounced. Three categories are used to describe how standards are complied with. These are as follows:

- **Met:** means that no action is required as the service/centre has fully met the standard and is in full compliance with the relevant regulation where applicable.
- **Met in some respect only:** means that some action is required by the service/centre to fully meet a standard.
- **Not met:** means that substantial action is required by the service/centre to fully meet a standard or to comply with the relevant regulation where applicable.

Inspectors will also make a determination on whether the centre is in compliance with the Child Care (Standards in Children's Residential Centres) Regulations, 1996. Determinations are as follows:

- **Regulation met:** the registered provider or person in charge has complied in full with the requirements of the relevant regulation and standard.
- **Regulation not met:** the registered provider or person in charge has not complied in full with the requirements of the relevant regulations and standards and substantial action is required in order to come into compliance.

National Standards Framework

1.1 Centre Description

This inspection report sets out the findings of an inspection carried out to determine the on-going regulatory compliance of the centre with the standards and regulations and the operation of the centre in line with its registration. The centre was granted its first registration on the 03rd of August 2021. At the time of this inspection the centre was in its first registration and was in year two of the cycle. The centre was registered without attached conditions from the 03rd of August 2021 to the 03rd of August 2024.

The centre was registered to provide single occupancy care for one young person from age thirteen to seventeen years on admission. The model of care strived to meet young people '*where they are at*' and accepts that each young person was doing the very best they can, given the current resources (intrinsic and extrinsic) at their disposal. The approach was influenced by the principals of Gestalt Psychotherapy which offered a holistic view that people are intricately linked to and influenced by their environments and that all people strive toward growth and balance. Young people were provided with opportunities to develop relationships with caring adults who role model appropriate ways of dealing with emotions, life challenges and day to day lived experiences in a lived environment. There was one young person living in the centre at the time of the inspection.

1.2 Methodology

The inspector examined the following themes and standards:

Theme	Standard
1: Child-centred Care and Support	1.6
3: Safe Care and Support	3.1, 3.2
4: Health, Wellbeing and Development	4.2

Inspectors look closely at the experiences and progress of children. They considered the quality of work and the differences made to the lives of children. They reviewed documentation, observed how professional staff work with children and each other and discussed the effectiveness of the care provided. They conducted interviews with the relevant persons including senior management and staff, the allocated social workers and other relevant professionals. Wherever possible, inspectors will consult with children and parents. In addition, the inspectors try to determine what the centre knows about how well it is performing, how well it is doing and what improvements it can make.

Statements contained under each heading in this report are derived from collated evidence. The inspectors would like to acknowledge the full co-operation of all those concerned with this centre and thank the young people, staff and management for their assistance throughout the inspection process

2. Findings with regard to registration matters

At the time of this inspection the centre was registered from the 03rd August 2021 to the 03rd August 2024. This is a draft report and the decision regarding the continued registration status of the centre is pending.

A draft inspection report was issued to the registered provider, senior management, centre manager on the 10th February 2023 and to the relevant social work departments on the 10th February 2023. The registered provider was required to submit both the corrective and preventive actions (CAPA) to the inspection and monitoring service to ensure that any identified shortfalls were comprehensively addressed. The suitability and approval of the CAPA was used to inform the registration decision. The centre manager returned the report with a CAPA on the 24th February 2023. Following review by inspectors the CAPA was returned to the provider as they were not satisfied that all actions were being adequately addressed. The provider returned the CAPA on the 3rd March 2023. This was deemed to be satisfactory and the inspection service received evidence of the issues addressed.

The findings of this report and assessment of the submitted CAPA deem the centre to be continuing to operate in adherence with regulatory frameworks and standards in line with its registration. As such it is the decision of the Child and Family Agency to register this centre, ID Number: 198 without attached conditions from the 03rd August 2021 to the 03rd August 2024 pursuant to Part VIII, 1991 Child Care Act.

3. Inspection Findings

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events
Regulation 17: Records

Theme 1: Child-centred Care and Support

Standard 1.6 Each child is listened to and complaints are acted upon in a timely, supportive and effective manner.

Inspectors met with the young person, spoke with the allocated social worker, interviewed staff members and reviewed documentation during the course of inspection and from this it was evident on the whole that the young person was being listened to and their views taken into account in relation to their placement. It was clear from observations that the young person had built positive relationships with certain staff members within the house and viewed the house as their home. There was a culture of openness with the young person evidenced by staff completing daily paperwork in the kitchen, the young person invited to sit in on handover and an open-door office.

There was a complaints policy in place that was consistent with legislation, regulations and best practice. There was a young persons' handbook provided upon admission. This included the rights of the young person along with a section on complaints. From review this required updating and did not fully reflect the organisation's policy on complaints. Whilst it highlighted the young person could fill out a form if they had a complaint, it didn't detail the complaints process or what to do if they weren't happy with how the complaint was handled or the outcome. Inspectors saw evidence of a number of complaints being recorded and reported, however, there were some deficits noted in relation to this. Whilst the centre manager provided a detailed section on evidence in response to the complaints, there was no evidence to show how outcomes were discussed with the young person, when or by whom. Inspectors also noted in one instance the young person had complained on three separate occasions in relation to car usage in the house. Two of these complaints were of a similar nature and the young person identified they were not happy with the outcome. There was no evidence to show this had been escalated through the appeals process. The head of services informed inspectors that they viewed this as a recruitment issue therefore it was excluded from the appeals process as per their complaints policy. The issue at hand was the lack of availability of drivers due to two non-drivers on shift. This impacted on the young person on both days due

to the rural location of the centre and lack of public transport available and was viewed by inspectors as a rostering issue as opposed to a recruitment issue and as such the appeals process should have been enacted due to the impact on the young person on those days. The social worker confirmed they were aware of the complaints however had not had the opportunity to speak with the young person in relation to same.

Inspectors met with the young person and found their knowledge on advocacy groups lacking. This was the young person's first residential placement. While they were provided with a booklet upon admission outlining roles, there was limited evidence to show this had been revisited through individual work. They were not aware of Empowering People In Care (EPIC) and the role they could provide, they were confused as to the purpose of their Guardian ad Litem, believing them to be a solicitor, and they were of the understanding the inspectors were members of the Gardaí. The centre manager must ensure that individual work is completed with the young person to help them understand different professional roles and how these persons can advocate for them and ensure professionals are invited to meet with the young person to explain their roles. Neither the young person nor staff interviewed were aware of the Tusla *'Tell Us'* complaints and feedback procedure and its purpose, it is important that both staff and young people have a working knowledge of same.

All complaints recorded were evident on the young person's care file. There was a complaints register on file however there were no headings evident and these should be updated to allow for tracking and oversight. Inspectors did not see evidence of complaints being regularly reviewed or audited nor evidence to show learning was implemented to improve practice, for example in the aforementioned complaints there was no evidence of discussions occurring at team level or management level to be mindful of rostering needs even in the case of short notice sick leave.

Compliance with Regulations	
Regulation met	**Regulation 5** **Regulation 16** **Regulation 17**
Regulation not met	**None identified**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed.**
Practices met the required standard in some respects only	**Standard 1.6**

Practices did not meet the required standard	**Not all standards were assessed.**

Actions required

- The registered provider must ensure the young persons' handbook is updated to reflect the organisations complaints policy.
- The centre manager must ensure that when a young person is unhappy with the outcome of complaints the appeals process is utilised.
- The centre manager must ensure that individual work is completed with the young person to help them understand different professional roles and how these can advocate for them.
- The centre manager must ensure staff and young people are familiar with Tusla Tell Us complaints and feedback procedure.
- The registered provider must ensure complaints are regularly reviewed and learning is implemented to improve practices in the centre.

Regulation 5: Care Practices and Operational Policies
Regulation 16: Notification of Significant Events

Theme 3: Safe Care and Support

Standard 3.1 Each Child is safeguarded from abuse and neglect and their care and welfare is protected and promoted.

There were policies in place to protect young people from all forms of abuse and neglect and these were in line with relevant legislation. Inspectors interviewed staff members and found them to be knowledgeable in relation to safeguarding, aware of their role as mandated persons and the procedures for recording and reporting disclosures. They were also aware of who the designated liaison person (DLP) was and the role they undertook. Training certs were on file for all staff members in the Children's First E-Learning module. There was not a list of mandated persons maintained by the centre and one must be devised. Whilst there was a child safeguarding statement and compliance letter in place, staff interviewed were not familiar with the risks associated with same.

Inspectors saw evidence of a number of child protection and welfare reporting forms (CPWRFs) on file. There was evidence of attempts being made by the centre to have

these reviewed and brought to a conclusion by the social work department. The social worker was of the opinion that the level of CPWRFs submitted was a testament to the work being completed by the staff team to ensure the young person felt safe and supported in placement.
Inspectors reviewed a sample of individual work that was carried out with the young person. The evidence of discussions around keeping safe were limited. While there were some discussions around drug misuse, there were no discussions relating to other pertinent issues arising in the young person's life that would be deemed risk taking behaviours including sexual education, internet / social media usage and keeping safe in the community. While individual areas of vulnerability were identified, individual safeguards implemented were not of a robust nature and did not have adequate control measures identified or the potential impact of the risk identified. The organisation did have a bullying policy in place however there were some safeguarding risks identified through the inspection process that were not adequately risk assessed including cyber bullying. Risk management will be discussed further under Standard 3.2 of this report.

Inspectors reviewed staff personnel files. Other than child protection training, there were no training certificates evident on personnel files. One staff member did not have the required parchments on file to verify they had a qualification. One staff member, while they had appropriate Irish vetting, did not have the appropriate overseas police declarations required on file. Another staff member did not have a third reference, this was subsequently sent to inspectors post inspection. Two staff members were without the relevant qualifications as required by the child care (standards in residential care) 1996 regulation 7 and as outlined in the Alternative Care Inspection and Monitoring Service Memo on minimum requirements on staffing numbers and qualifications. One of these was in the process of gaining a recognised qualification. Both had been recruited following the issue of the memo setting out minimum requirements and were deemed unqualified.

There was a policy on protected disclosures. Staff interviewed were knowledgeable on this and one staff member informed inspectors they had utilised it previously and action had been taken in relation to the concerns raised.

Inspectors noted there was no specific audit relating to child protection however there were a number of fortnightly visits recorded by the head of services along with a full theme 3 audit completed in May 2022, prior to the previous inspection. From review of the theme 3 audit, it was a quantitative analysis as opposed to qualitative analysis of documentation within the centre. Fortnightly reports focused on different

aspects of care each visit. There had been no review of child protection documented on these records since August 2022. A number of these fortnightly reports did not contain action plans and the ones that did have action plans attached did not note all deficits found within the reports. The head of services must ensure there is a robust system in place to frequently monitor child protection.

Standard 3.2 Each child experiences care and support that promotes positive behaviour.

The organisation had a number of policies in place to support positive behaviour management. Training in a recognised model of behaviour management was provided to staff members however there were a number of deficits identified. At the time of inspection;

- Two staff members' training was up to date.
- One staff member had last received training in March 2021,
- three staff members training were out of date by one month,
- two staff members training was out of date by four months,
- four staff members had completed days one and two of training but had not completed the remainder of the course thus leaving them uncertified.

The organisation's policy highlighted this training was mandatory, along with mandatory six monthly refreshers. This deficit in training was not identified on the centre risk register nor was it identified in theme 3 audits that were carried out.

The young person demonstrated a high level of substance misuse both within and external to the centre. Inspectors were informed that a 'harm reduction' model was being utilised to address behaviours. The team had not received specific training in relation to 'harm reduction' approaches and had no training in any specific model of assisting young people to address substance misuse. Three staff members were due to complete training in the community reinforcement approach before the end of January however this training focused on attempting to improve the persons environment to disincentivise drug use as opposed to focusing on a harm reduction approach. The head of services and centre manager must ensure they review the current approaches being utilised and its effectiveness to manage substance misuse in the absence of appropriate training.

From a review of documents to support the management of behaviours inspectors noted that the placement plan in place at the time of inspection did not address substance misuse concerns nor identify goals to work towards. There was clear guidance being provided to the staff team in relation to the management of substance

misuse in a document entitled 'behaviour that challenges' however inspectors noted from a review of significant event notifications (SENs) that this guidance was not being followed through in practice. There was an individual crisis support plan in place that did not account for the lack of training in a recognised model of behaviour management, in particular the intervention aspect.

Inspectors noted some concerns relating to the management of substance misuse within the centre that were linked to the young person's free time planning. From a review of documents, it was evident that the young person was utilising the staff team to bring them to another county to obtain illegal substances before returning almost immediately to the centre. Inspectors spoke with the young person's allocated social worker who expressed similar concerns and highlighted a meeting had been arranged to discuss concerns. There was evidence on file to show two meetings had been convened in August and November 2022 to address behaviours, however, minutes on file were not adequate to allow inspectors insight into discussions. There were SENs on file on at least four separate occasions that showed staff continued to facilitate these journeys after the latest meeting in November 2022 occurred. There was no evidence to show the young person had been challenged on their behaviours or consequences initiated. Management interviewed informed inspectors the centre utilised a non-confrontational approach when working with the young person. Staff members interviewed felt there was an element of fear within the staff team which held them back from challenging the young person. The social worker was of the same opinion and a referral had been submitted by the social work department for ACTS services to work with the team to support them to work more effectively with the young person. This service was yet to come on board at the time of inspection.

Significant Event Review Group meetings occurred monthly however were not covered under the organisation's policies and procedures. These were attended by the head of services, centre manager and sporadically members of the staff team. Staff interviewed informed inspectors they had not been afforded the opportunity to attend some of the reviews that had occurred despite their involvement in the incidents, nor were they aware of learnings as a result of the reviews. Inspectors saw one serious incident that had been reviewed in October 2022, neither staff members involved were in attendance, the minutes did not record any learnings and concerns in relation to staff practice were not addressed within the SERG minutes.

The centre had a pet dog. Inspectors noted there was no policy relating to animals in the centre and found that there had been a number of incidents in which animal abuse was demonstrated by the young person. On the day of inspection, inspectors

observed the dog displaying distress and reacting to raised voices which presented as a cause for concern. This was explored with the centre manager and head of services both of whom stated the dog was a therapeutic benefit to the young person. There were no adequate risk assessments in place nor was the introduction of the dog addressed in the placement plan. While there was evidence of one individual work record on file that the issue of mistreating the dog had been addressed there was no further individual work completed with the young person in relation to their behaviours and consequences of this behaviour. Inspectors asked for a review to be conducted as a matter of priority in relation to the dog's place in the centre and were subsequently informed the dog was rehomed on the 19th January 2023.

There were a number of restrictive practices in place at the time of inspection. These were documented in a register and within risk assessments. Upon review of documentation it was evident that the register and risk assessments did not correspond in relation to their review dates.

Inspectors noted there was no specific audit relating to behaviour management, however there were a number of fortnightly visits recorded by the head of services along with a full theme 3 audit completed in May 2022, prior to the previous inspection and admission of the current young person. From review of the theme 3 audit, it was a quantitative analysis as opposed to qualitative analysis of documentation within the centre. Fortnightly reports focused on different aspects of care each visit. There had been no review of behaviour management documented on these records since August 2022.

A number of these fortnightly reports did not contain action plans and the ones that did have action plans attached did not note all deficits found within the reports. The head of services must ensure there is a robust system in place to frequently monitor approaches to behaviour management.

Compliance with Regulation	
Regulation met	**Regulation 16**
Regulation not met	**Regulation 5**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed.**
Practices met the required standard in some respects only	**Standard 3.1**
Practices did not meet the required standard	**Standard 3.2**

Actions required:

- The centre manager must ensure that appropriate individual work is being completed (and attempts to complete are being documented) with the young person in relation to self-care and keeping safe.
- The centre manager must ensure that all safeguarding related risks are identified and robustly risk assessed.
- The head of services must ensure all staff personnel files have required documentation and ensure staff are recruited in line with the minimum staffing requirements relating to qualifications.
- The head of services and centre manager must ensure staff training is brought up to date as a matter of priority.
- The centre manager must ensure placement planning is reflective of care planning and current issues for the young person with clear, identifiable goals.
- The head of services and centre manager must ensure the staff teams practice is congruent with guidance documents.
- The centre manager must ensure the individual crisis support plan accounts for the lack of training within the team and appropriately risk assessed.
- The head of services and centre manager must ensure they review the current approaches being utilised and its effectiveness to manage substance misuse in the absence of appropriate training.
- The head of services must review the effectiveness of the current SERG process for learning and changes to practice.
- The centre manager must ensure restrictive practices are reviewed regularly and documented appropriately.
- The head of services must ensure there is a robust system in place to frequently monitor approaches to behaviour management.

Regulation 10: Health Care
Regulation 12: Provision of Food and Cooking Facilities

Theme 4: Health, Wellbeing and Development

Standard 4.2 Each child is supported to meet any identified health and development needs.

Policies noted that health would be a core element of the placement plan and associated weekly plans. This was not evident in practice. From review of the placement plan on file at the time of inspection there were no goals relating to diet and nutrition nor was this addressed in the care plan from when the young person was admitted. Inspectors did not see any associated individual work being carried out with the young person in relation to a nutritional programme or educating them around the impact of their diet choices.

Inspectors noted the young person appeared to struggle with their diet. The social worker informed inspectors they had previously queried the young person's food intake both verbally and in email. Inspectors reviewed logs for the nine days prior to the inspection and found on five of these days the young person had a takeaway. On the other occasions their food consisted of unhealthy options such as sweets, energy drinks, and fried foods cooked in house. The young person appeared to have no set routine regarding lunch or dinner due to sleeping late in the day. The organisations policies noted that 'fast food and take out would be restricted to once a week at a maximum'. This was not reflected in practice.

The young person had access to a general practitioner within the local vicinity. The young person had moved into the centre seven months prior to inspection and a medical intake assessment was still outstanding. There were also actions from their care plan (July 2022) outstanding. Whilst the centre manager and head of services informed inspectors attempts had been made to support the young person to attend these appointments, there was no evidence on file to demonstrate the young person had been offered and encouraged to attend these appointments. The social worker for the young person had not been made aware there were medical appointments outstanding for the young person.

The organisation had a medicine management policy in place that was in line with legislative requirements and best practice. The young persons files included records of medical and health information relating to the young person.

Compliance with Regulation	
Regulation met	**Regulation 10** **Regulation 12**
Regulation not met	**None Identified**

Compliance with standards	
Practices met the required standard	**Not all standards were assessed.**
Practices met the required standard in some respects only	**Not all standards were assessed.**
Practices did not meet the required standard	**Standard 4.2**

Actions required

- The centre manager must ensure there is appropriate placement planning and individual work relating to diet and nutrition.
- The centre manager must ensure individual work is completed and documented in relation to attendance at health-related appointments.

4. CAPA

Theme	Issue Requiring Action	Corrective Action with Time Scales	Preventive Strategies To Ensure Issues Do Not Arise Again
1	The registered provider must ensure the young persons' handbook is updated to reflect the organisations complaints policy.	Young person's booklet has been updated to reflect the organisational complaints policy, this will be discussed in the house meeting on 05.03.23.	Centre manager to review the young person's booklet before admission of a new young person to ensure it reflects all policies accurately.
	The centre manager must ensure that when a young person is unhappy with the outcome of complaints the appeals process is utilised.	A key-working session to occur to support the young person's understanding of the complaints process, this will occur by the 31.03.23. Centre manager to complete the appeals process for all complaints that the young person is unhappy with the outcome.	HoS to review all open complaints fortnightly to ensure complaints are being accurately recorded and followed up on.
	The centre manager must ensure that individual work is completed with the young person to help them understand different professional roles and how these can advocate for them.	Key-working to be completed with the young person to support a better understanding of the professionals in their lives and how their roles can support/benefit their experience. This will be completed by the 31.03.23.	Centre manager to review the monthly key working schedule to ensure all advocates available to the young Person are accurately and continually discussed with them. HoS to review the individual work as part of monthly audits.

	The centre manager must ensure staff and young people are familiar with Tusla Tell Us complaints and feedback procedure.	The team are now aware of the Tusla Tell Us complaints and feedback procedure. This was completed in the team meeting on 01.02.23 and will be refreshed as needed. A key working session to occur with the young person to familiarise them with the process on 05.03.23.	Centre manager to ensure all staff are adequately trained in the Tell us policy and that this policy is reviewed as and when needed.
	The registered provider must ensure complaints are regularly reviewed and learning is implemented to improve practices in the centre.	HOS has retrospectively reviewed all complaints on file in the centre as of 20/2/23 and supports with the response and actions taken by the centre manager. Complaints were added to the supervision and monthly managers meeting agendas to provide regular discussion and attention for each new complaint.	Complaints are an established and permanent agenda item on individual supervisions at a frontline, middle management and senior Management level. Complaints are an on-going permanent agenda item on Monthly Management meetings where Senior and Director Management attend.
3	The centre manager must ensure that appropriate individual work is being completed (and attempts to complete are being documented) with the young	Discussion to occur with the staff team regarding promoting self-care on a daily basis. This will be logged clearly within the daily logs such as encouragement to attend	Centre manager to ensure that all attempts to complete individual work are documented. HoS to review individual work as part of

	person in relation to self-care and keeping safe.	appointments, eat healthy balanced meals and encourage a health sleep routine. Any keyworking or attempts at key working will also be clearly documented. Keeping safe has been added to the placement plan as of 28.02.23 and any work completed regrading this will be clearly documented.	the monthly audits.
	The centre manager must ensure that all safeguarding related risks are identified and robustly risk assessed.	There are now risk assessments on file for internet/social media usage, sex education and keeping safe in the community. These are in place as of the 02.03.23.	Centre manager to complete weekly reviews of the risk register and review in team meetings. Centre manager to share risks rated high with HoS weekly.
	The head of services must ensure all staff personnel files have required documentation and ensure staff are recruited in line with the minimum staffing requirements relating to qualifications.	Review of Personnel Files completed by HOS on 20/2/23. Satisfied that all current staff members files are fully compliant. One staff member has since been re-deployed as they did not possess applicable qualifications. Qualifications were not on file for 2 staff members this has since been uploaded. All staff have full compliance files available.	New Induction process activated in the company to ensure that files are fully compliant. File review of all teams scheduled for Workforce Development Meetings on a weekly basis.

	The head of services and centre manager must ensure staff training is brought up to date as a matter of priority.	Training-Training schedules reviewed at recent Monthly Managers Meeting- 16/2/23 and deficits identified. Outstanding training scheduled for all staff members has been scheduled to be completed by 31.03.23.	Training Officer has scheduled monthly Training Meetings with house managers and HOS to review training needs in each house and plan/schedule the trainings for each team member pro-actively. House manager to schedule trainings on to teams rosters. HOS notification circulated to entire workforce directing that attendance at scheduled training is mandatory.
	The centre manager must ensure placement planning is reflective of care planning and current issues for the young person with clear, identifiable goals.	Safety and self-care have been added as goals for the young person. This will include all aspects of safety/self-care including substance misuse. This will outline the plan for the month ahead with keyworking also. The progress will be updated clearly with oversight by the House manager. The purpose of the placement plan will be reviewed with the staff team in the next team meeting.	House manager will review the placement plan each month to ensure it is reflective of the planning and work completed with the young person. The HOS will review placement plans during audits.
	The head of services and centre manager must ensure the staff teams	Supports Plans are reviewed in the team meetings to ensure all team members are	HOS will complete an audit to ensure compliance from staff members relating to

	practice is congruent with guidance documents.	aware of the plans. Staff practice and adherence to the young person's plans to be reviewed in supervisions as a standing agenda item.	practice following guidance in documents.
	The centre manager must ensure the individual crisis support plan accounts for the lack of training within the team and appropriately risk assessed.	The ICSP has been updated to reflect the lack of training in the team and a risk assessment completed outlining the potential impact of this. All Staff have been scheduled onto mandatory training in the month of March.	There is a training needs meeting scheduled on a monthly basis within the organisation and appropriate plans will be developed here to offer the mandatory training. Centre Manager to review the training register on a monthly basis.
	The head of services and centre manager must ensure they review the current approaches being utilised and its effectiveness to manage substance misuse in the absence of appropriate training.	Key-working will remain on-going with the young person to address their substance misuse. Three of the team have been trained in Community Reinforcement Training with the view for it to be rolled out to the rest of the team. The risk assessment for free time has been reviewed at the team meeting on 22.02.23 and centre manager will continue to monitor the implementation of this and will address any deviation from this plan	Centre manager will review approaches within the team and address in team meetings and supervisions. HoS through review of all SENS, on call logs weekly, monthly review of daily logs and fortnightly house visits, ensures compliance with guidance docs.

		with staff members.	
	The head of services must review the effectiveness of the current SERG process for learning and changes to practice.	SERG effectiveness was reviewed at recent Monthly Management Meeting 16/2/23 and restructuring of the meetings has been established to provide more robust review and learning opportunities	SERG meetings now scheduled weekly instead of every 3 weeks. Time increased from 1.5 hours every 3 weeks to approx 5 hours monthly.
	The centre manager must ensure restrictive practices are reviewed regularly and documented appropriately.	Centre Manager reviewed the current restrictive practise register and supporting risk assessment on 16.02.23, this has been shared with the SW Dept.	Centre Manager will review the restrictive practise register on a monthly basis within the manager meeting. Updates will be shared with the team and SW Dept.
	The head of services must ensure there is a robust system in place to frequently monitor approaches to behaviour management.	HOS reviews all SENs and monitors for approaches to Behaviour Management. Strategy meeting held on 7/2/23 to review notification pathways and response timeframes. HOS responds to a random selection or SENs which require instruction on approaches to Behaviour Management.	Weekly SERG reviews to monitor behaviour management. TCI refresher training scheduled on an on-going basis. Monthly training meetings to access training needs of staff. All SENs received by HOS and Directors

		SERGs are attended by a certified TCI instructor to ensure competent and appropriate implementation of behaviour management approaches. HOS signs off on Behaviour Support Plans.	
4	The centre manager must ensure there is appropriate placement planning and individual work relating to diet and nutrition. The centre manager must ensure individual work is completed and documented in relation to attendance at health-related appointments.	Self-care has been added as a goal to the placement plan. This will include keyworking on diet, nutrition and health related appointments. Attendance to appointments will be pulled from the daily logs monthly to review the number of appointments the young person has attended or not attended, and key-working will be based around this. A professionals meeting will be scheduled if further work is required.	HOS to review placement plans during audits. House manager to review placement plan goals and progress thoroughly with the staff team during team meetings each month. Supervisions with keyworkers will focus on the placement plan goals and how best to support the young person in meeting these goals.